

§ 422.210

42 CFR Ch. IV (10–1–00 Edition)

(g) *Pooling of patients.* Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several M+C organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

(1) It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group.

(2) The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled.

(3) The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled.

(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category.

(5) The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

(h) *Periodic surveys of current and former enrollees.* An M+C organization must conduct periodic surveys of current and former enrollees where substantial financial risk exists. These periodic surveys must—

(1) Include either a sample of, or all, current Medicare/Medicaid enrollees in the M+C organization and individuals disenrolled in the past 12 months for reasons other than—

(i) The loss of Medicare or Medicaid eligibility;

(ii) Relocation outside the M+C organization's service area;

(iii) For failure to pay premiums or other charges;

(iv) For abusive behavior; and

(v) Retroactive disenrollment.

(2) Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

(3) Measure the degree of enrollees'/disenrollees' satisfaction with the quality of the services provided and the degree to which the enrollees/disenrollees have or had access to the services provided under the M+C organization; and

(4) Be conducted no later than 1 year after the effective date of the M+C organization's contract and at least annually thereafter.

(i) *Sanctions.* An M+C organization that fails to comply with the requirements of this section is subject to intermediate sanctions under subpart O of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.210 Disclosure of physician incentive plans

(a) *Disclosure to HCFA—(1) Basic requirement.* Each M+C organization must provide to HCFA descriptive information about its physician incentive plan in sufficient detail to enable HCFA to determine whether that plan complies with the requirements of § 422.208. Reporting should be on the HCFA PIP Disclosure Form (OMB No. 0938–0700).

(2) *Content.* The information must include at least the following:

(i) Whether services not furnished by the physician or physician group are covered by the incentive plan.

(ii) The type or types of incentive arrangements, such as, withholds, bonus, capitation.

(iii) The percent of any withhold or bonus the plan uses.

(iv) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.

(v) The patient panel size and, if the plan uses pooling, the pooling method.

(vi) If the M+C organization is required to conduct enrollee surveys, a summary of the survey results.

(3) *When disclosure must be made to HCFA.* An M+C organization must disclose annually to HCFA the physician incentive arrangements that are effective at the start of each year. In addition, HCFA does not approve an M+C organization's application for a contract unless the M+C organization discloses the physician incentive arrangements effective for that contract.

(b) *Disclosure to Medicare beneficiaries—Basic requirement.* An M+C organization must provide the following information to any Medicare beneficiary who requests it:

(1) Whether the M+C organization uses a physician incentive plan that affects the use of referral services.

(2) The type of incentive arrangement.

(3) Whether stop-loss protection is provided.

(4) If the M+C organization was required to conduct a survey, a summary of the survey results.

§ 422.212 Limitations on provider indemnification.

An M+C organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the M+C organization's denial of medically necessary care:

(a) A physician or health care professional.

(b) Provider of services.

(c) Other entity providing health care services.

(d) Group of such professionals, providers, or entities.

§ 422.214 Special rules for services furnished by noncontract providers.

(a) *Services furnished by non-section 1861(u) providers.* (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan or M+C private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

(2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an M+C plan also apply to the payment described in paragraph (a)(1) of this section.

(b) *Services furnished by section 1861(u) providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordi-

nated care plan or M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.86(d)) of this chapter that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.86(d) concerns calculating payment for direct graduate medical education costs.)

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.216 Special rules for M+C private fee-for-service plans.

(a) *Payment to providers—(1) Payment rate.* (i) The M+C organization must establish uniform payment rates for items and services that apply to all contracting providers, regardless of whether the contract is signed or deemed under paragraph (f) of this section.

(ii) Contracting providers must be reimbursed on a fee-for-service basis.

(iii) The M+C organization must make information on its payment rates available to providers that furnish services that may be covered under the M+C private fee-for-service plan.

(2) *Payment to contract providers.* For each service, the M+C organization pays a contract provider (including one deemed to have a contract) an amount that is equal to the payment rate under paragraph (a)(1) of this section minus any applicable cost-sharing.

(3) *Noncontract providers.* The organization pays for services of noncontract providers in accordance with § 422.100(b)(2).

(4) *Service furnished by providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.86(d) of this chapter) that it could collect if the beneficiary were enrolled in original Medicare.

(b) *Charges to enrollees—(1) Contract providers.* (i) Contract providers and "deemed" contract providers may